PRELIMINARY ASSESSMENT/APPLICATION FOR CAPITAL ASSISTANCE
FOR AGENCIES SERVING THE ELDERLY AND PERSONS WITH DISABILITIES
SECTION 5310
GRANT 0031 FY 2005

LEAD AGENCY:

TRANSPORTATION PROJECT*

1. Identification of Applicant Agency or Organization:

   a. Legal name of agency_____

   b. Address_____

   _____

   c. Telephone number:_____ Fax number:

   d. Project Director or Supervisor_____

   e. E-mail/Internet address:

2. Name of geographic area(s) to be served:

   a. Cities and/or Counties served_____

3. Types of transportation service to be provided: (% of use)

   a. Scheduled, fixed route _____

   b. Scheduled, non-fixed route_____

   c. Demand responsive (dial-a-ride)_____

   d. Other (specify)_____

4. Vehicle or other equipment requested:

Vehicle Type	Regular	Center Aisle	Raised Roof	Cutaway	Local Match
10-16 Pas Van	_____	_____	_____	_____	_____
10-16 Pas/Lift	_____	_____	_____	_____	_____
17-24 Pas Bus	_____	_____	_____	_____	_____
17-24 Pas/Lift	_____	_____	_____	_____	_____
7 Pas Minivan	_____				_____
Minivan/Ramp	_____				_____
Vehicle Rehab	_____				_____
Other	_____				
	_____				

5. Vehicle is intended to:
   a. Replace existing service _____
   b. Expand existing service _____
   c. Start new service _____

6. If new vehicle is intended to replace existing service, indicate the following on the vehicle to be replaced/rehabilitated:

Make	Model	Year	Lift	Mileage/Date	Capacity	Condition	VIN

7. Estimated number of days per month the requested transportation service will be offered: (1 month = 30 days) ____. Estimated hours/day ____.

8. Estimate the number of one-way trips by county:

	County	County	County	County	Total
a. Elderly/month	_____	_____	_____	_____	
b. Disabled/month	_____	_____	_____	_____	
c. Minorities/month	_____	_____	_____	_____	
d. Other/month	_____	_____	_____	_____	
e. Total/month	_____	_____	_____	_____	

9. Identify the clientele category your agency will serve:
   a. Elderly
   b. Disabled: Physically _____ Mentally __
   c. Minorities: Black _____ Hispanic_____
      Asian_____ American Indian/Alaskan
   d. Low Income
   e. Other specific client groups (specify)

10. Equipment requested other than vehicle related (lower priority):

    A. Describe the equipment being requested:

    B. Describe the benefits for the service and its riders:

11. Project Description: (Use more sheets if necessary)

    A. Describe current transportation services:

    B. How will the proposed vehicle fit into these services:

    C. Will the proposed vehicle be used for other services such as “Meals on Wheels”? If yes, please describe:

    D. Describe agency fleet, giving number of Section 5310, 5311, 5309 and agency vehicles, as well as average age and mileage and accessibility of each:

    E. Describe transportation services of other providers in the area you are proposing to serve:

F. Discuss how you plan to coordinate services with other agencies serving the elderly and persons with disabilities and with other programs such as Section 5311, Job Access, etc. Discuss efforts to coordinate with other providers, especially taxi companies:

G. Local Match Source(s):

_____ _____

Signature Date

*Please complete a separate application for each vehicle requested.
A request from an applicant for a single vehicle serving more than one (1) county can be applied for on a single form. EVERY section of the form should be addressed or the requested vehicle's overall ranking could be compromised.